

2018 Medical plan comparison

		Consumer Basic Limited	Consumer Basic Choice		Consumer Plus Limited	Consumer Plus Choice	
		Memorial Hermann network only	Tier I	Tier II	Memorial Hermann network only	Tier I	Tier II
RATES							
Based on 24 pay periods	Employee only	\$46	\$56		\$63	\$81	
	Employee + spouse	\$244	\$271		\$271	\$338	
	Employee + child(ren)	\$164	\$183		\$185	\$232	
	Employee + family	\$326	\$365		\$361	\$451	
HEALTHFUND							
	Employee only	\$400	\$400		\$650	\$650	
	Employee + spouse	\$650	\$650		\$900	\$900	
	Employee + child(ren)	\$650	\$650		\$900	\$900	
	Employee + family	\$900	\$900		\$1,150	\$1,150	
PLAN LIMITS							
Annual deductible	Individual	\$2,250	\$2,250	\$2,750	\$1,750	\$1,750	\$2,250
	Family	\$4,500	\$4,500	\$5,000	\$3,500	\$3,500	\$4,000
Annual out-of-pocket max (includes all medical and pharmacy deductibles, copays and coinsurance)	Individual	\$5,500	\$5,500	\$6,850	\$4,500	\$4,500	\$6,000
	Family	\$11,000	\$11,000	\$12,500	\$9,000	\$9,000	\$10,500
YOUR COST FOR COVERED SERVICES							
Preventive care exams		Free	Free		Free	Free	
Office visit	Primary care (PCP)	25%	25% (all PCPs are Tier I)		20%	20% (all PCPs are Tier I)	
	Non-designated specialists (NDS) ¹	25%	25% (all NDSs are Tier I)		20%	20% (all NDSs are Tier I)	
	Designated specialists	25%	25%	45%	20%	20%	35%
Inpatient—hospital (pre-certification required)		25%	25%	45% + \$500 copay per admission ²	20%	20%	35% + \$500 copay per admission ²
Outpatient—hospital (pre-certification required)		25%	25%	45%	20%	20%	35%
Outpatient—freestanding and surgical center (pre-certification required)		25%	25%		20%	20%	
Emergency care		35% + \$250 copay (waived if admitted)	35% + \$250 copay (waived if admitted)		30% + \$250 copay (waived if admitted)	30% + \$250 copay (waived if admitted)	
Urgent care facility		25%	25%		20%	20%	
Lab, X-ray, diagnostic mammogram, diagnostic scans (MRI, MRA, CAT, PET) outpatient hospital		25%	25%	45%	20%	20%	35%
Lab, X-ray, diagnostic mammogram, diagnostic scans (MRI, MRA, CAT, PET) freestanding facility, independent lab		25%	25%		20%	20%	
Maternity—delivery		25%	25%	45%	20%	20%	35%
Mental health and substance abuse—inpatient and outpatient		25%	25%		20%	20%	
PRESCRIPTION							
Annual prescription deductibles ³	Generic	\$0					
	Brand	\$200					
Prescription drug 30-day retail	Generic	\$20					
	Preferred brand	\$40					
	Non-preferred brand	\$80					
Prescription drug 90-day mail or retail	Generic	\$40					
	Preferred brand	\$100					
	Non-preferred brand	\$200					

1. These are in-network specialists who are not in the designated specialty areas.

2. Limited to two \$500 copays per plan year.

3. The deductible applies once per year per person and a copay may also be requested.